UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Update to the Work Group on Rural Health Care on Maryland's Eastern Shore

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Who Is University of Maryland Shore Regional Health?

Up to 21st Century:

Three Independent Community Hospitals: Kent-Queen Anne's Hospital/Chester River Hospital, Memorial Hospital at Easton, Dorchester General Hospital

1996: Memorial Hospital at Easton and Dorchester General Hospital affiliate to become Shore Health System

2006: Shore Health System merges with University of Maryland Medical System

2008: Chester River Hospital affiliates with University of Maryland Medical System

2013: Shore Health System and Chester River Hospital affiliate to become University of Maryland Shore Regional Health

About Shore Regional Health
Fiscal Year 2016

✓ **Employees**	**2053**
✓ **Physicians/providers employed**	**70**
✓ **Annual Budget**	**$299,850,000**
✓ **Payroll**	**$110,081,000**
✓ **Admissions (Total UMSRH)**	**10,769**
✓ **Outpatient Visits (Total UMSRH)**	**196,783**
✓ **Emergency Department Visits (UMSRH)**	**79,104**

The Rural Health Care Physician and Provider Workforce

University of Maryland Community Medical Group (UMCMG) is the employed physician and provider group of UM Shore Regional Health, serving patients in the five counties of Maryland's mid-ShoreUM CMG employs 70 providers– primary care and specialists– in this region.

28 Primary Care providers (Family practice, Internal Medicine, Pediatrics and OB/GYN*)

UM CMG's local annual budgeted payroll is $29.1 million.

76% of this payroll is physicians and providers salaries

Total number of UMCMG non-physician/provider employees is 169 at UM SRH locations

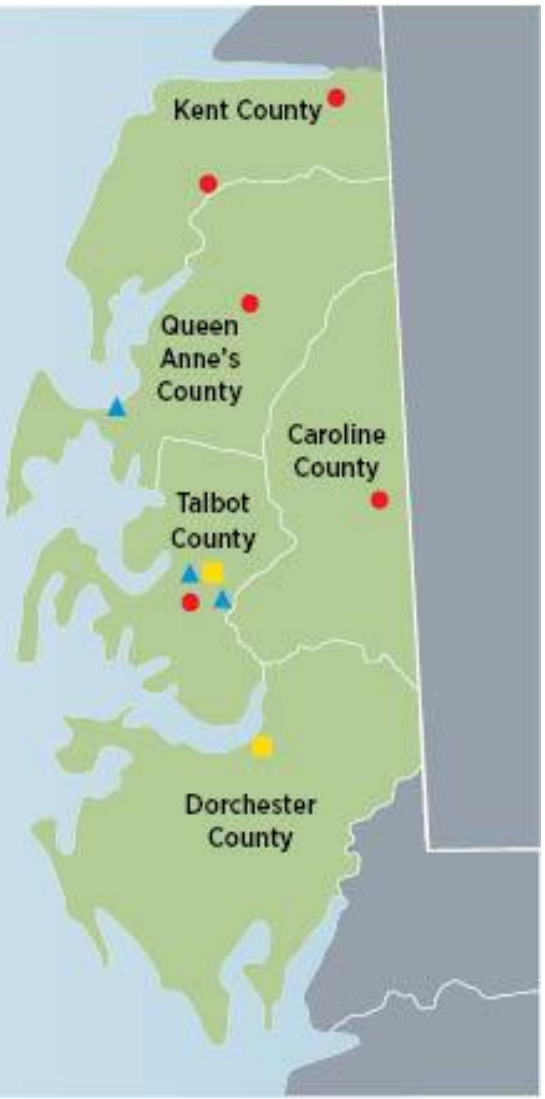
*In rural communities, OB/GYNs are significant providers of primary care access

UM CMG Primary Care Locations

University of Maryland Community Medical Group - Primary Care
- Centreville
- Chestertown
- Denton
- Easton
- Galena

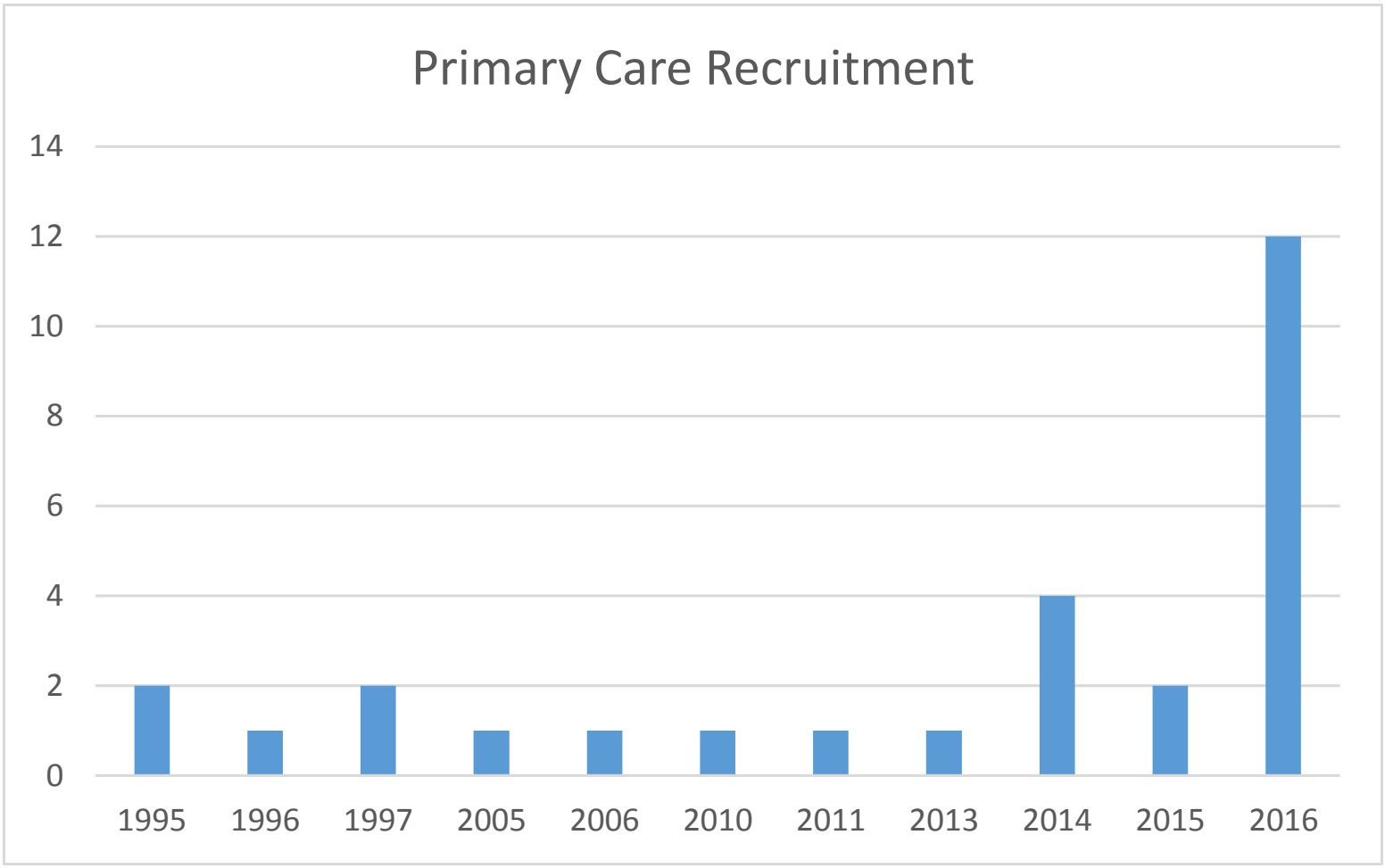
University of Maryland Community Medical Group - Pediatrics
- Cambridge
- Easton

University of Maryland Community Medical Group - Women's Health
- Easton (two locations)
- Queenstown



Rural Primary Care

- Providers have become employed in greater numbers over past three decades and increasingly, 2014-2016:



Rural Primary Care

- Increasingly, advanced practice providers (NP, PA, CNM) enhance primary care access along with physician partners

- Of 28 employed primary care providers, 21 were recruited to the area and 7 existing providers sought employment

Primary Care Providers, UM Community Medical Group

UM CMG – Primary Care (Centreville)
Brittany Cutler, NP
Michael Roberts, M.D.
Jeffrey Ukens, MD

UM CMG – Primary Care (Denton)
Katherine Cook, MD
Kim Herman, MD
Shirley Seward, CRNP
Wafik Zaki, MD

UM CMG – Primary Care (Galena)
Lisa Hall, NP
Marcia Reynolds, NP

UM CMG – Primary Care (Chestertown)
Susan K. Ross, MD

Primary Care Providers, UM Community Medical Group

UM CMG – Primary Care- (Easton)
Nina Eshaghi, MD
Carolyn Helmly, MD
Kevin Tate, MD

UM CMG – Pediatrics (Easton)
Ellie Spurry Christ, CRNP
Richard Fritz, MD
Marilyn Gall, CRNP
Mark Langfitt, MD
Maria Maguire, MD

UM CMG – Pediatrics (Cambridge)
Gina Exantus-Bernard, MD
Ahmed Gawad, MD

Primary Care Providers, UM CMG

<u>UM CMG – Women's Health</u>
Rebecca Ailstock CNM
Michell Jordan, CNM
Barbara Keirns, MD
Brittany Krautheim, CNM
Aisha Siddiqui, MD

<u>UM CMG – Women's Health (Easton; Queenstown)</u>
Jen Dyott, CRNP
Dale Jafari, CRNP
William Katz, M.D.

Locations of Inpatient Care to Which Employed Providers Refer

Referrals based upon:

- Capacity available locally UM SMC- Chestertown, UM SMC-Dorchester, UM SMC-Easton

- Regional options centralized (e.g., OB, stroke, behavioral health, cardiac, trauma) UM SMC Easton

- Statewide options (UMMS system options, patient/provider choice, centers of excellence) UMMC Baltimore

Patients Prefer Local Options When Possible!

Identifying Primary Care Gaps and Addressing Needs

- Medical Staff Development Plans and Physician Needs Assessments engage physicians and providers in gap identification, retirement and practice growth planning

- Service Delivery Plan involved physicians and community partners

- Outreach to both affiliated/employed and community based/independent practices

RECRUITMENT AND RETENTION ADDRESS NEEDS

Collaboration with Independents and Community Partners to Improve Care Coordination AND provider retention

Partnerships and collaboration with others improve both care coordination AND provider satisfaction

Examples:

•Mobile Integrated Health Care program with Queen Anne's County and likely future counties' EMS in region

•Choptank Community Health (FQHC) partnership for obstetrics and emergency patients

•Nursing home collaboratives

Support for and Collaboration with Independent Providers Strengthens Care

- Recruitment support
- Practice support agreements
- Information Technology
- Facilitating provider to provider communications
- Loan repayment agreements
- Primary Care “Summits” around shared issues and topics of interest
- Educational Programs
- Practice Managers meetings and educational sessions
- Social events

Challenges to Provider Recruitment in the Rural Community

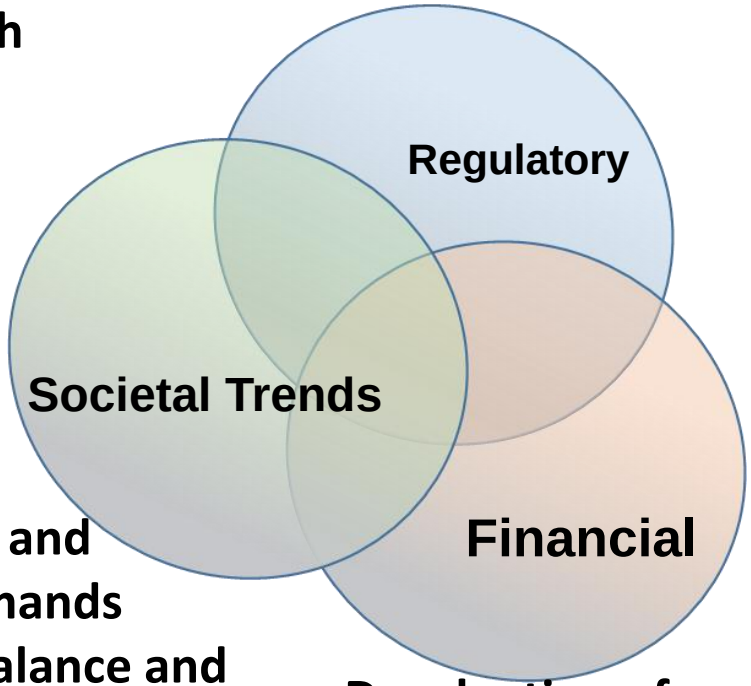
No licensed practitioners = No Care

Escalation of costs due to:

- Recruitment and retention barriers
- Competition

Overlapping Pressures on Private Practices

- Devaluation of intangible assets and the loss of "partnership"
- Demands of electronic records
- Demands of CMS reimbursement programs & practice transformation to population health



- Patient expectations and customer service demands
- Focus on work-life balance and trend toward shift work
- Physician burn out

- Devaluation of provider work (less $/RVU)
- Increasing non-reimbursable activities
- The push towards outpatient management of diseases

Take home points…

1. **Rural healthcare = less population density, less revenue, as well as increased fixed and per capita costs**
2. **Private practice = small business**
3. **Value of a private practice is only its *tangible* assets; charts, good will etc. are of no financial value to a partner.**
4. **Recruiting and retaining providers = competing on salary and quality of life (i.e. on-call frequency, patient care volumes, etc.)**
5. **The hospital budget is the current funding source for gaps in community care.**

What Do We Do?

Rural medical practices in the Maryland are not sustainable when only providing patient care – how do we adapt?

- **Medical directorships**
- **On-call stipends**
- **Practice support agreements (for recruiting)**
- **Get out of private practice – look for employment or merge**
- **Salaries > revenue for many employed providers**

***All of these solutions shift the burden of cost to hospitals and thus to the hospital rate-based payment system**

Possible Solutions

If Maryland's waiver is designed to grant *all citizens* access to high-quality, cost-effective healthcare, then the State has an obligation to support areas where market forces do not support recruiting, retaining, and developing a sufficient provider workforce

Possible Solutions

Timeline	Idea	Details
Short Term	Adjust hospital rates to reflect shifts in rural healthcare costs	Need a rural "modifier" for hospital rates
Long Term	Attract new providers with debt relief	Loan repayment opportunities
	Offer incentives and support to sustain small, private practices	Small Business Grants and loans
	Train new providers in the community	Rural Residency Programs
	Attract experienced providers with tax incentives and debt relief	Retirement Incentives

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Community Health Needs Assessment and Action Planning

2016 Community Health Needs Assessment Findings

Local Context, Overall Findings

•Subpopulations within counties have higher uninsured, unemployed, and low income residents

•Lack of public transportation system *appropriate for health care*

•Limited number of non-profits and private organizations as stakeholders to help share in filling gaps for vulnerable population

• Health workforce shortage that includes primary care, behavioral health and specialty care

Differences at the County Level

- **The five counties differ in their capacity to:**

- Provide accessible public health interventions in the public schools
- Establish relationships and involvement within their respective minority communities
- Involve and sustain interest at local policy level

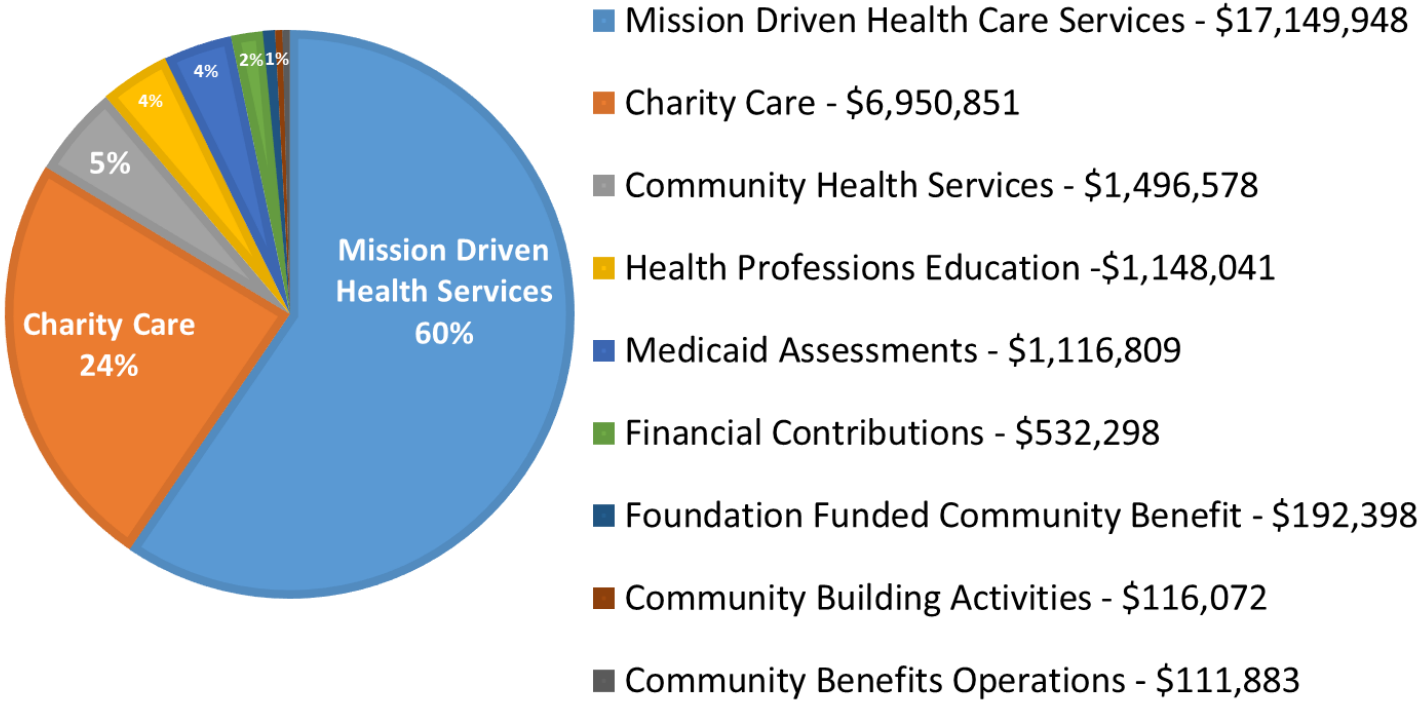
2016 Community Health Needs Assessment Findings

Top five priorities for five-county region

1. Chronic Disease Management (obesity, hypertension, diabetes, smoking)
2. Behavioral Health
3. Access to care (transportation, primary care, specialists, cost)
4. Cancer
5. Outreach & Education (preventive care, screenings, health literacy)

Community Benefits Financial Report

Making a Difference: Last fiscal year, University of Maryland Shore Regional Health provided **$28,814,878** to benefit the five-county region



Community Benefit Initiatives

- *Chronic Disease Management-Obesity, Hypertension, Diabetes, Smoking*
  - Nutrition Education
  - Diabetes Education Classes
  - Shore Kids Camp (Diabetes)
  - Blood Pressure Screenings
  - Shore Post Acute Care Clinic
  - Shore Wellness Partners Community Case Management
  - Community Exercise Program, Stroke Survivors

- *Behavioral Health*
  - Recovery for Shore
  - Shore Behavioral Health Bridge Clinic

Community Benefit Initiatives

- *Wellness and Access*
  - Physician/Provider Subsidies
  - Urgent Care
  - Wellness for Women- Breast Center
  - Screenings
  - Patient Medication Assistance
  - Patient Transportation Assistance
  - Antithrombosis Clinic
- *Programs for Aging Population*
  - Home Ports Annual Aging Symposium
  - Queen Anne's County Annual Senior Summit

Community Benefit Initiatives

- *Cancer*
  - Shore Regional Outreach-Breast Center
  - Prostate Cancer Screenings
  - Nutrition for Cancer Recovery
  - Community Education- Cancer Survivorship

Community Based Wellness Education Programs

Wellness Education Programs
- Accessible Care, Comprehensive Support: Cancer Prevention and Support
- Keeping Your Child Safe on the Field: How to Prevent Sports-Related Injuries
- Living a Healthy Life with Diabetes
- Minimally Invasive Spinal Surgery
- Palliative Care and Advance Care Planning
- Preventing Falls
- Stroke Signs, Symptoms and Recovery

Support Groups
- Addiction and mental illness
- Alzheimer's disease
- Breast Cancer
- Cancer
- Childbirth (labor and delivery, breastfeeding and parent education)
- Diabetes
- Heart Disease
- Prostate Cancer
- Stroke Recovery

Screenings and Outreach
- Cancer- Prostate, Breast, Skin
- Pulmonary Lung Function
- Pain Self Management
- Blood Pressure
- Diabetes
- Fall Prevention